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PROCEDURE EDUCATION LITERATURE

We recommend that you read this handout carefully in order to prepare yourself or family members for the proposed procedure. In doing so, you will benefit both the outcome and safety of the procedure. *If you still have any questions or concerns, we strongly encourage you to contact our office prior to your procedure so that we may clarify any pertinent issues. "An educated patient is the best patient"*

CYSTOCELE REPAIR

Definition

Cyst = of or pertaining to the urinary bladder

Cele = balloon like in appearance

A cystocele in its literal sense means bladder appearing like a balloon. Perhaps it was referred to this way because a "dropped bladder" for which this term really describes, may appear balloon-like when the bladder is prolapsing (protruding through or down from) from the vagina.

Risk factors for this defect are thought to include any one or a combination of:

- multigravida (multiple pregnancies), but more from multiparity (multiple deliveries) especially when associated with large babies or prolonged, difficult vaginal deliveries
- obesity
- chronic coughing (perhaps smoking in and of itself)
- years of strenuous activity or heavy lifting
- large fibroid uterus
- post-menopausal state
- prior history of hysterectomy

There are a variety of effective operations to restore the bladder to its normal anatomic position. Some are performed through an incision in the abdomen, and others only through incisions in the vagina. Some may require a combination. The type of approach will depend on your anatomy, whether the cystocele repair is being done in conjunction with another surgery (see below), your prior surgical history, and the preference of your surgeon. The pros and cons of each will have already been discussed with you in your consultation.

Often, this surgery is combined with other procedures, such as those to correct urinary incontinence (the involuntary loss of urine) or with hysterectomy. A common misconception is that a cystocele (dropped bladder) causes urinary incontinence. By itself, it typically does not. When the neck of the bladder and the urethra (tube through which you urinate) have lost their support structures, this is when you typically get urinary incontinence. This type of incontinence is termed "stress" incontinence because urine is lost with *stress* on the top of the bladder (coughing, sneezing, lifting, etc.). This condition, termed *urethral hypermobility*, often exists as well when a cystocele is present because they have the same causative factors. A significant cystocele, by itself, can actually *obstruct* the flow of urine by causing a "kink" in the urethra. Therefore, patients with cystoceles may not have stress incontinence and may actually complain of obstructive symptoms. Such symptoms are a delay in the initiation of the stream, a need to push the urine out, and a slow or intermittent stream. Patients with cystoceles may also complain of symptoms of frequency (urinating often) or urgency (a frequent sudden urge to urinate).

Prior to your surgery, we may have performed a urodynamic test (UDT). This is a diagnostic procedure used to specifically evaluate problems of urinary incontinence or other problems with urination. Often, conditions causing incontinence need to be evaluated prior to recommending a cystocele repair. Occasionally, the diagnosis (based on your symptoms and physical examination) is straightforward, and a UDT is therefore unnecessary.

Preparation

As with all procedures in which anesthesia is administered, you will be asked not to eat or drink anything after a certain time, usually midnight, on the evening prior to your surgery. You may brush your teeth in the morning but should not swallow the water. If you are on medications that must be taken, you will have discussed this with us and/or the anesthesiologist and instructions will have been given to you. The procedure will not be

performed if you are currently taking, or have recently taken any medication that may interfere with your ability to clot your blood ("blood thinners, aspirin, anti-inflammatory medicines, etc..."). The most common of these medications are aspirin and all related pain relievers or anti-inflammatory compounds (whether prescription or over-the-counter). ***Please refer to the attached list and tell us if you took any of these within the past 10 days.*** If your new medication is not on the list, alert us immediately so that we may ensure optimal procedure safety. We will have reviewed all of your current medications with you during the pre-operative/pre-procedure consultation. You are obligated to inform us if anything has changed (medication or otherwise) since your previous visit.

*It is probably to your advantage not to strain to have a bowel movement in the week after the procedure. We therefore recommend that for the entire week before the procedure, you avoid constipating foods such as rice, bananas, and red meat. You should be eating lots of fruits and vegetables as well as oatmeal and cereals. If you have a known problem of constipation, you should administer an enema one hour before bed the night before your procedure.

Procedure

You will be lying on your back with your knees bent and heels in stirrups as you would for a pelvic examination. The procedure usually takes approximately one to three hours depending on an individual's anatomy, your prior surgical history, and whether the cystocele repair will be combined with other procedures.

If being combined with a procedure for incontinence (typically a pubovaginal sling or PVS), a suprapubic tube (small catheter placed through the lower abdomen and into the bladder) may be inserted. If a PVS is going to be performed simultaneously, we will also furnish you with the education literature for this procedure.

The cystocele repair involves elevating the bladder using either your own tissue, or using a combination of your tissue with a "mesh." The mesh can include material that is entirely synthetic (made of artificial substances), or of specially processed tissue from another species. Each has its advantages and disadvantages, and the material will have been discussed with you in your consultation. Regardless, through a vaginal, abdominal, or a combination of incisions, strong supporting structures or tissue in your pelvis are sewn together underneath the base of your bladder in order to restore it to its natural position and provide support. If a mesh is used, the mesh will be placed under your bladder like a hammock and sewn to the supporting structures in your pelvis. During the procedure, we may perform cystoscopy (placing a small telescope into the bladder to visualize the inside) to ensure that everything is correctly positioned. The incisions are then closed. Sterile dressings are applied. Sometimes, we place a vaginal packing (gauze) in your bladder for one or two nights. A suprapubic tube may have been placed or you may have a catheter placed in the bladder through the urethra.

Post Procedure

You will be in the recovery room for a short time before being sent to your hospital bed. Most patients usually will stay one or two nights in the hospital, although it is possible to have a cystocele repair as an ambulatory procedure. There may be some discomfort around the incision sites, within the vagina, and on the lower abdomen depending on the procedure you had performed. Most patients have some sense of urgency (the feeling of a need to urinate). There will be a small dressing over the abdominal incision site (if one was made), which is to remain until your follow up visit unless otherwise instructed.

The Suprapubic Tube (SPT): You may have this if you have had a simultaneous procedure (i.e. pubovaginal sling) performed for incontinence. Sometimes, it is placed even if only a cystocele repair was done. If placed, you will be discharged home with the SPT. It may remain for a week (or more) until you are urinating well and adequately emptying your bladder. You will be instructed on how to easily open and close the drainage switch. The tube may serve two purposes:

1. You will attempt to urinate when you go home. If you are unsuccessful, you can simply open the tube and drain the urine from your bladder. When you are completely empty (no more draining from the tube), you will close the switch and allow your bladder to fill again over the next several hours (time will vary according to how much fluid you are drinking). When you get another sensation to urinate, you will go to the bathroom and attempt to go. Again, if you cannot, you will open the tube, empty the bladder, close the tube, and try again later.
2. If you do urinate, you will open the tube when you believe that you are done urinating. The reason for doing so is to determine whether you are emptying your bladder fully. If there is urine remaining in the bladder, you will record how many ounces were left. You will do this each time you urinate so that you and your surgeon know if you are effectively emptying your bladder and ready to have the tube removed.

Urethral Catheter: Sometimes a catheter is left in the urethra and removed a few days or week later to see if you can urinate on your own. If you cannot, it can be replaced, or you can learn self-catheterization.

Self-Catheterization: If an SPT is not placed, you may be instructed on how to catheterize yourself. The indications to do so may be the same.

In other words, you would do it if you cannot urinate yet. You may also be asked to catheterize to measure what is left in the bladder after urinating.

There may be small blood staining on the wound dressing. If the dressing becomes soaked, or you see active blood oozing, please contact us immediately. You may shower two days after surgery, but no bathing or swimming (unless otherwise instructed). Some surgeons may ask you to take warm baths a couple of times a day a few days after your surgery. It is normal to have some bloody discharge from the vagina for a day or two. If you have significant bleeding, you should call our office. We ask that you refrain from any strenuous activity or heavy lifting until your follow up office visit. Every patient has some degree of swelling and bruising, and it is not possible to predict in whom this might be minimal or significant. It is very important that you intermittently apply ice to the abdominal area as soon as you return home for 24 hours as instructed.

We strongly encourage you to take at least one week off from work and perhaps more if your occupation requires strenuous activity or heavy lifting. In the first 48 hours, it is to your advantage to minimize activity and to often rest in a lying down position. Periodic walking is encouraged. Some patients have almost no discomfort while others are somewhat uncomfortable for a few days to weeks. Severe pain is unlikely but possible. We may provide you with a prescription for pain medication to alleviate most of the discomfort. Take this medication as prescribed and as needed. An antibiotic prescription may also be given and should be taken until completion. If any side effects occur, contact our office immediately.

**You must refrain from any strenuous activity or heavy lifting until we tell you otherwise. Sexual activity of any sort is absolutely prohibited (usually four to six weeks) until we tell you that you may resume.*

Expectations of Outcome

If the cystocele was present for a long time, you may have actually become accustomed to the abnormal changes in your anatomy. After this type of operation, it may take some time before you are fully comfortable. The bladder may need time to adjust to its restored position.

There is an entity termed "bladder instability" that should be understood. It is actually not a complication of the surgery because we expect some degree of its presentation in anywhere from 30 to 40% of patients following repair of a significant cystocele or urethral hypermobility. Because the bladder has been replaced to its normal position, you may develop urinary frequency and/or urgency (a sensation to urinate urgently). When severe, this rarely can be associated with urge-type incontinence (strong urge to void with an uncontrolled loss of some urine). The symptoms are usually mild and resolve with time. In few patients, medications could be necessary to relax the bladder. Very rarely are other treatments necessary.

Possible Complications of the Procedure

All surgical procedures, regardless of complexity or time, can be associated with unforeseen problems. They may be immediate or even quite delayed in presentation. While we have discussed these and possibly others in your consultation, we would like you to have a list so that you may ask questions if you are still concerned. Aside from anesthesia complications, it is important that every patient be made aware of all possible outcomes, which may include, but are not limited to:

- Urinary Tract Infection or Sepsis: Although we may give you antibiotics prior to and after the operation, it is possible for you to get an infection. The most common type is a simple bladder infection (after the catheter is removed) that presents with symptoms of burning urination, urinary frequency and a strong urge to urinate. This will usually resolve with a few days of antibiotics. If the infection enters the bloodstream, you might feel very ill. This type of infection can present with both urinary symptoms and any combination of the following: fevers, shaking chills, weakness or dizziness, nausea and vomiting. You may require a short hospitalization for intravenous antibiotics, fluids, and observation. This problem is more common in diabetics, patients on long-term steroids, or in patients with disorders of the immune system.
- Wound Infection: The incision sites can become infected. While it typically resolves with antibiotics and local wound care, occasionally, part or all of the incision may open and require revision and or catheter replacement. ****If you have symptoms suggesting any of the above after your discharge from the hospital, you must contact us immediately or go to the nearest emergency room.***
- Treatment failure: Although usually associated with a high success rate, the procedure can fail in the immediate post-operative period, or months to years later. In this regard, the cystocele can return
- Urinary Retention: Retention is the inability to urinate. It is rare in patients who undergo a cystocele repair; and is more common in patients who also have a simultaneous incontinence procedure. However, if retention ensues, we would need to place a catheter in your bladder until it can be further evaluated. Alternatively, you may be taught to self-catheterize (see above).
- Blood Loss/Transfusion: The vaginal region is quite vascular. Usually blood loss in this procedure is minimal to moderate. In some cases blood loss can be significant enough to necessitate transfusion.
- Painful intercourse and Vaginal Shortening: After cystocele surgery, the shape of the vaginal vault can change. In certain cases, the depth of the vagina may be lessened and the angle changed. While usually not a problem, some women may complain of pain or difficulty with intercourse. Sometimes it is temporary, but it can also be permanent.
- Deep Vein Thrombosis (DVT)/Pulmonary Embolus (PE): In any operation (especially longer operations), you can develop a clot

in a vein of your leg (DVT). Typically, this presents two to seven days (or longer) after the procedure as pain, swelling, and tenderness to touch in the lower leg (calf). Your ankle and foot can become swollen. ***If you notice these signs, you should go directly to an emergency room and also call our office:*** Although less likely, this blood clot can move through the veins and block off part of the lung (PE). This would present as shortness of breath and possibly chest pain. We may sometimes ask the medical doctors to be involved with the management of either of these problems.

- **Mesh Erosion:** It is possible for the mesh material to erode through the tissue that surrounds it. If the vaginal tissue breaks down, the mesh can usually be removed with a minimal procedure. Often, the bladder is still supported because it has scarred into place. On the contrary, if the back of the mesh erodes into the bladder, the surgical removal is more involved, and could result in problems with the bladder in the future.
- **Bleeding/Hematoma:** When a small blood vessel continues to ooze or bleed after the procedure is over, the area of collected blood is referred to as a hematoma. The body normally re-absorbs this collection over a short period of time, and surgical drainage is rarely necessary.
- **Lower Extremity Weakness/Numbness:** This, too, is a rare event which may arise due to your position on the operating table. It is possible in procedures in which you are in the lithotomy (legs up in the air) for a long period. The problem is usually self-limited, with a return to baseline expected.
- **Injury from Suprapubic Tube:** If a suprapubic tube is being placed, it can rarely puncture a structure adjacent to the bladder. Although rare in any instance, the small intestine is the most commonly involved organ. When recognized, a general surgeon may be consulted to repair the intestine or other organ.
- **Chronic Pain:** As with any procedure, a patient can develop chronic pain in an area that has undergone surgery. Typically, the pain disappears over time, although some feeling of numbness may persist. If persistent, further evaluation may be necessary.
- **Transferred viral infection:** With the use of human cadaveric material, transferred virus is theoretically possible. The processing of this material is quite extensive. *With use in tens of thousands of patients, we are not aware of a single published case of transferred viral infection.*

Patient Signature

Date

Patient Name Patient ID #

Date

Physician Signature

Date

Witness

Date

The information contained in this Medical Informed Consent Form ("Consent Form") is intended to solely inform and educate and should not be used as a substitute for medical evaluation, advice, diagnosis or treatment by a physician or other healthcare professional. Please call your doctor if you have any questions.